PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

SENATE ENROLLED ACT No. 311

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 8.1. State Employee Health Benefits; Provider Payment

Sec. 1. As used in this chapter, "administrator" means:

(1) the state personnel department;

(2) an entity with which the state contracts to administer health coverage under IC 5-10-8-7(b); or

(3) a prepaid health care delivery plan with which the state contracts under IC 5-10-8-7(c).

Sec. 2. As used in this chapter, "clean claim" means a claim submitted by a provider for payment under a health benefit plan that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Sec. 3. As used in this chapter, "covered individual" means an individual who is:

(1) covered under a self-insurance program established under IC 5-10-8-7(b) to provide group health coverage; or

(2) entitled to services under a contract for health services entered into or renewed under IC 5-10-8-7(c).

Sec. 4. As used in this chapter, "health benefit plan" means a self-insurance program established to provide group health

coverage as described in IC 5-10-8-7(b), or a contract for health services as described in IC 5-10-8-7(c).

Sec. 5. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 6. (a) The administrator shall pay or deny each clean claim in accordance with section 7 of this chapter.

(b) An administrator shall notify a provider of any deficiencies in a submitted claim not less than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of an administrator to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

Sec. 7. (a) The administrator shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, not more than thirty (30) days after the date the claim is received by the administrator.

(2) If the claim is filed on paper, not more than forty-five (45) days after the date the claim is received by the administrator.

(b) If:

(1) the administrator fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the administrator subsequently pays the claim;

the administrator shall pay the provider that submitted the claim interest on the health benefit plan allowable amount of the claim paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or

(B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), the administrator shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

Sec. 8. A provider shall submit only the following forms for payment by an administrator:

(1) HCFA-1500.

(2) HCFA-1450 (UB-92).

(3) American Dental Association (ADA) claim form.

SECTION 2. IC 27-8-5-3 IS AMENDED TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2001]: Sec. 3. (a) Except as provided in subsection (c), each policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one (1) or more of the provisions corresponding provisions of different wording approved by the commissioner that are in each instance no less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows: TIME LIMIT ON CERTAIN DEFENSES: (A) After two (2) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two (2) year period.

The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy of denial of a claim during such initial two (2) year period, nor to limit the application of subsection (b), (1), (2), (3), (4), and (5) in the event of misstatement with respect to age or occupation or other insurance.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium:

(1) until at least age fifty (50); or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue;

may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE": After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.

(B) No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy

shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.

(3) A provision as follows: GRACE PERIOD: A grace period of (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision: "Unless not less than thirty (30) days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

Each policy in which the insurer reserves the right to refuse renewal on an individual basis shall provide, in substance, in a provision of the policy, in an endorsement on the policy, or in a rider attached to the policy, that subject to the right to terminate the policy upon non-payment of premium when due, such right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary, or in the case of lapse and reinstatement at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force. The preceding sentence shall not apply to accident insurance only policies.

(4) A provision as follows: REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. Provided, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer

shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) until at least fifty (50) years of age; or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

(5) A provision as follows: NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may insert the following between the first and second sentences of the above provision:

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, the insured shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insurer's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.

(6) A provision as follows: CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in

the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(7) A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

(8) A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid:

(1) immediately upon receipt of due written proof of such loss; **or**

(2) in accordance with IC 27-8-5.7;

whichever is more favorable to the policyholder. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof. **This provision must reflect compliance with IC 27-8-5.7.**

(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $ _____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by

marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

For the purposes of this section a "minor" is a person under the age of eighteen (18) years. A person eighteen (18) years of age or over is competent, insofar as the person's age is concerned, to sign a valid release.

(10) A provision as follows: PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows: LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(12) A provision as follows: CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(13) A provision as follows: GUARANTEED RENEWABILITY: In compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), renewability is guaranteed.

(b) Except as provided in subsection (c), no policy delivered or issued for delivery to any person in Indiana shall contain provisions respecting the matters set forth below unless the provisions are in the words in which the provisions appear in this section. However, the

insurer may use, instead of any provision, a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any substitute provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A provision as follows: CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows: MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) A provision as follows: OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $ _____ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the insured's estate. Or, instead of that provision:

Insurance effective at any one (1) time on the insured under a like policy or policies, in this insurer is limited to the one (1) such policy elected by the insured, the insured's beneficiary or the insured's estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) A provision as follows: INSURANCE WITH OTHER INSURER: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion of the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party

liability coverage shall be included as "other valid coverage".

(5) A provision as follows: INSURANCE WITH OTHER INSURERS: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase "-OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage to the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage".

(6) A provision as follows: RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the

insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars ($200) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(1) until at least fifty (50) years of age; or

(2) in the case of a policy issued after forty-four (44) years of age, for at least five (5) years from its date of issue.

The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute (including any worker's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

(7) A provision as follows: UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(8) A provision as follows: CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(9) A provision as follows: ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(10) A provision as follows: INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(c) If any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(d) The provisions which are the subject of subsections (a) and (b), or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

(e) "Insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

(f)(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than is provided in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(f)(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(g) The commissioner may make reasonable rules under IC 4-22-2 concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper, or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.

SECTION 3. IC 27-8-5-15 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 15. (a) No policy of blanket accident and sickness insurance shall be delivered or issued for delivery in this state unless it conforms to the requirements of this

section.

(1) A policy may be issued to any common carrier or to any operator, owner or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group of persons who may become passengers defined by reference to their travel status on such common carrier or such means of transportation.

(2) A policy may be issued to an employer, who shall be deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

(3) A policy may be issued to a college, school, or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal, or governing board of any such educational unit, who or which shall be deemed the policyholder, covering students, teachers, or employees.

(4) A policy may be issued to any religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to any activity or activities or operations sponsored or supervised by such policyholder.

(5) A policy may be issued to a sports team, camp, or sponsor thereof, which shall be deemed the policyholder, covering members, campers, employees, officials, or supervisors.

(6) A policy may be issued to any volunteer fire department, first aid, emergency management, or other such volunteer organization, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(7) A policy may be issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

(8) A policy may be issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(9) A policy may be issued to cover any other risk or class of risks

which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

(b) Each such policy shall contain in substance provisions which in the opinion of the commissioner are not less favorable to the policyholder and the individual insured than the following:

(1) A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in absence of fraud, be deemed a misrepresentation and not a warranty, and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application. Such person, his beneficiary, or assignee, shall have the right to make written request to the insurer for a copy of such application and the insurer shall, within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.

(2) A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable and that subsequent written

proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable:

(A) immediately upon receipt of due written proof of such loss; **or**

(B) in accordance with IC 27-8-5.7;

whichever is more favorable to the policyholder, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the injured or sick individual when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

The insurer may omit from a policy any portion of any of the above provisions which is not applicable to that policy. An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate.

(c) All benefits under any blanket accident and sickness policy shall be payable to the person insured, or to the insured's designated beneficiary or beneficiaries, or to the insured's estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to the insured's parent,

guardian, or other person actually supporting the insured. However, the policy may provide in substance that all or any portion of any benefits provided by any such policy on account of hospital, nursing, medical, or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but, the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligations with respect to the amount of insurance so paid.

(d) This section applies only to policies delivered or issued for delivery in Indiana after August 19, 1975.

SECTION 4. IC 27-8-5-19, AS AMENDED BY P.L.14-2000, SECTION 58, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]: Sec. 19. (a) As used in this chapter, "late enrollee" has the meaning set forth in 26 U.S.C. 9801(b)(3).

(b) A policy of group accident and sickness insurance may not be issued to a group that has a legal situs in Indiana unless it contains in substance:

(1) the provisions described in subsection (c); or

(2) provisions that, in the opinion of the commissioner, are:

(A) more favorable to the persons insured; or

(B) at least as favorable to the persons insured and more favorable to the policyholder;

than the provisions set forth in subsection (c).

(c) The provisions referred to in subsection (b)(1) are as follows:

(1) A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the policy will continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period. A provision under this subdivision may provide that the insurer is not obligated to pay claims incurred during the grace period until the premium due is received.

(2) A provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two (2) years after its date of issue, and that no statement made by a person covered under the policy relating

to the person's insurability may be used in contesting the validity of the insurance with respect to which the statement was made, unless:

(A) the insurance has not been in force for a period of two (2) years or longer during the person's lifetime; or

(B) the statement is contained in a written instrument signed by the insured person.

However, a provision under this subdivision may not preclude the assertion at any time of defenses based upon a person's ineligibility for coverage under the policy or based upon other provisions in the policy.

(3) A provision that a copy of the application, if there is one, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are to be deemed representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the insured person or, in the event of death or incapacity of the insured person, to the insured person's beneficiary or personal representative.

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

(5) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy and that is not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice, diagnosis, care, or treatment was received by the person or recommended to the person during the six (6) months before the enrollment date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of:

(i) the end of a continuous period of twelve (12) months beginning on or after the enrollment date of the person's

coverage; or

(ii) the end of a continuous period of eighteen (18) months beginning on the enrollment date of the person's coverage if the person is a late enrollee.

This subdivision applies only to group policies of accident and sickness insurance other than those described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(6) A provision specifying any additional exclusions or limitations applicable under the policy with respect to a disease or physical condition of a person that existed before the effective date of the person's coverage under the policy. An exclusion or limitation that must be specified in a provision under this subdivision:

(A) may apply only to a disease or physical condition for which medical advice or treatment was received by the person during a period of three hundred sixty-five (365) days before the effective date of the person's coverage; and

(B) may not apply to a loss incurred or disability beginning after the earlier of the following:

(i) The end of a continuous period of three hundred sixty-five (365) days, beginning on or after the effective date of the person's coverage, during which the person did not receive medical advice or treatment in connection with the disease or physical condition.

(ii) The end of the two (2) year period beginning on the effective date of the person's coverage.

This subdivision applies only to group policies of accident and sickness insurance described in section 2.5(a)(1) through 2.5(a)(8) of this chapter.

(7) If premiums or benefits under the policy vary according to a person's age, a provision specifying an equitable adjustment of:

(A) premiums;

(B) benefits; or

(C) both premiums and benefits;

to be made if the age of a covered person has been misstated. A provision under this subdivision must contain a clear statement of the method of adjustment to be used.

(8) A provision that the insurer will issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement that:

(A) explains the insurance protection to which the person insured is entitled;

(B) indicates to whom the insurance benefits are payable; and

(C) explains any family member's or dependent's coverage under the policy.

(9) A provision stating that written notice of a claim must be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy, but that a failure to give notice within the twenty (20) day period does not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give notice within that period and that notice was given as soon as was reasonably possible.

(10) A provision stating that:

(A) the insurer will furnish to the person making a claim, or to the policyholder for delivery to the person making a claim, forms usually furnished by the insurer for filing proof of loss; and

(B) if the forms are not furnished within fifteen (15) days after the insurer received notice of a claim, the person making the claim will be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which the claim is made.

(11) A provision stating that:

(A) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at reasonable intervals as may be required by the insurer;

(B) in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within ninety (90) days after the date of the loss; and

(C) the failure to furnish proof within the time required under clause (A) or (B) does not invalidate or reduce any claim if it was not reasonably possible to furnish proof within that time, and if proof is furnished as soon as reasonably possible but (except in case of the absence of legal capacity of the claimant) no later than one (1) year from the time proof is otherwise required under the policy.

(12) A provision that:

(A) all benefits payable under the policy (other than benefits for loss of time) will be paid ~~within forty-five (45) days after the insurer receives all information required to determine~~

~~liability~~ ~~under~~ ~~the~~ ~~terms~~ ~~of~~ ~~the~~ ~~policy~~ **in accordance with IC 27-8-5.7;** and

(B) subject to due proof of loss, all accrued benefits under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and any balance remaining unpaid at the termination of the period for which the insurer is liable will be paid as soon as possible after receipt of the proof of loss.

(13) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of benefits for loss of life is subject to the provisions of the policy if no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount of five thousand dollars ($5,000), to any relative by blood or connection by marriage of the person who is deemed by the insurer to be equitably entitled to the benefit.

(14) A provision that the insurer has the right and must be allowed the opportunity to:

(A) examine the person of the individual for whom a claim is made under the policy when and as often as the insurer reasonably requires during the pendency of the claim; and

(B) conduct an autopsy in case of death if it is not prohibited by law.

(15) A provision that no action at law or in equity may be brought to recover on the policy less than sixty (60) days after proof of loss is filed in accordance with the requirements of the policy and that no action may be brought at all more than three (3) years after the expiration of the time within which proof of loss is required by the policy.

(16) In the case of a policy insuring debtors, a provision that the insurer will furnish to the policyholder, for delivery to each debtor insured under the policy, a certificate of insurance describing the coverage and specifying that the benefits payable will first be applied to reduce or extinguish the indebtedness.

(17) If the policy provides that hospital or medical expense coverage of a dependent child of a group member terminates upon

the child's attainment of the limiting age for dependent children set forth in the policy, a provision that the child's attainment of the limiting age does not terminate the hospital and medical coverage of the child while the child is:

(A) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and

(B) chiefly dependent upon the group member for support and maintenance.

A provision under this subdivision may require that proof of the child's incapacity and dependency be furnished to the insurer by the group member within one hundred twenty (120) days of the child's attainment of the limiting age and, subsequently, at reasonable intervals during the two (2) years following the child's attainment of the limiting age. The policy may not require proof more than once per year in the time more than two (2) years after the child's attainment of the limiting age. This subdivision does not require an insurer to provide coverage to a mentally retarded or mentally or physically disabled child who does not satisfy the requirements of the group policy as to evidence of insurability or other requirements for coverage under the policy to take effect. In any case, the terms of the policy apply with regard to the coverage or exclusion from coverage of the child.

(18) A provision that complies with the group portability and guaranteed renewability provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

(d) Subsection (c)(5), (c)(8), and (c)(13) do not apply to policies insuring the lives of debtors. The standard provisions required under section 3(a) of this chapter for individual accident and sickness insurance policies do not apply to group accident and sickness insurance policies.

(e) If any policy provision required under subsection (c) is in whole or in part inapplicable to or inconsistent with the coverage provided by an insurer under a particular form of policy, the insurer, with the approval of the commissioner, shall delete the provision from the policy or modify the provision in such a manner as to make it consistent with the coverage provided by the policy.

SECTION 5. IC 27-8-5.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 5.7. Accident and Sickness Insurance; Provider Payment

Sec. 1. As used in this chapter, "accident and sickness insurance policy" has the meaning set forth in IC 27-8-5-1.

Sec. 2. As used in this chapter, "clean claim" means a claim submitted by a provider for payment under an accident and sickness insurance policy issued in Indiana that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Sec. 3. As used in this chapter, "insurer" means an insurance company issued a certificate of authority in Indiana to issue accident and sickness insurance policies. The term includes:

(1) a preferred provider plan (as defined in IC 27-8-11-1); and

(2) an insurance administrator that:

(A) collects charges or premiums; and

(B) adjusts or settles claims;

in connection with coverage under an accident and sickness insurance policy.

Sec. 4. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1.

Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with section 6 of this chapter.

(b) An insurer shall notify a provider of any deficiencies in a submitted claim not less than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of an insurer to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

Sec. 6. (a) An insurer shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer.

(2) If the claim is filed on paper, within forty-five (45) days after the date the claim is received by the insurer.

(b) If:

(1) an insurer fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the insurer subsequently pays the claim;

the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or

(B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), an insurer shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

Sec. 7. A provider shall submit only the following forms for payment by an insurer:

(1) HCFA-1500.

(2) HCFA-1450 (UB-92).

(3) American Dental Association (ADA) claim form.

Sec. 8. (a) If the commissioner finds that an insurer has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess an aggregate civil penalty against the insurer according to the following schedule:

(1) If the insurer has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).

(2) If the insurer has paid at least sixty percent (60%) but less than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the insurer has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

(b) In determining the amount of a civil penalty under this section, the commissioner shall consider whether the insurer's failure to achieve the standards established by this chapter is due to circumstances beyond the insurer's control.

(c) An insurer may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the insurer receives notice of the assessment of the fine.

(d) If the commissioner imposes a civil penalty under this

section, the commissioner may not impose a penalty against the insurer under IC 27-4-1 for the same activity.

(e) Civil penalties collected under this section shall be deposited in the state general fund.

SECTION 6. IC 27-13-36.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 36.2. Provider Payment

Sec. 1. As used in this chapter, "clean claim" means a claim submitted by a provider for payment for health care services provided to an enrollee that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

Sec. 2. As used in this chapter, "health maintenance organization" includes:

(1) an insurance administrator that:

(A) collects charges or premiums; and

(B) adjusts or settles claims;

in connection with coverage under a contract with a health maintenance organization; and

(2) a limited service health maintenance organization.

Sec. 3. (a) A health maintenance organization shall pay or deny each clean claim in accordance with section 4 of this chapter.

(b) A health maintenance organization shall notify a provider of any deficiencies in a submitted claim not less than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of a health maintenance organization to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

Sec. 4. (a) A health maintenance organization shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, not less than thirty (30) days after the date the claim is received by the health maintenance organization.

(2) If the claim is filed on paper, not less than forty-five (45) days after the date the claim is received by the health maintenance organization.

(b) If:

(1) a health maintenance organization fails to pay or deny a clean claim in the time required under subsection (a); and

(2) the health maintenance organization subsequently pays the claim;

the health maintenance organization shall pay the provider that submitted the claim interest on the lesser of the usual, customary, and reasonable charge for the health care services provided to the enrollee or an amount agreed to between the health maintenance organization and the provider paid under this section.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) thirty-one (31) days after the date the claim is filed under subsection (a)(1); or

(B) forty-six (46) days after the date the claim is filed under subsection (a)(2); and

(2) stops accruing on the date the claim is paid.

(d) In paying interest under subsection (b), a health maintenance organization shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

Sec. 5. A provider shall submit only the following forms for payment by a health maintenance organization:

(1) HCFA-1500.

(2) HCFA-1450 (UB-92).

(3) American Dental Association (ADA) claim form.

Sec. 6. (a) If the commissioner finds that a health maintenance organization has failed during any calendar year to process and pay clean claims in compliance with this chapter, the commissioner may assess an aggregate civil penalty against the health maintenance organization according to the following schedule:

(1) If the health maintenance organization has paid at least eighty-five percent (85%) but less than ninety-five percent (95%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of up to ten thousand dollars ($10,000).

(2) If the health maintenance organization has paid at least sixty percent (60%) but less than eighty-five percent (85%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least ten thousand dollars ($10,000) but not more than one hundred thousand dollars ($100,000).

(3) If the health maintenance organization has paid less than sixty percent (60%) of all clean claims received from all providers during the calendar year in compliance with this chapter, a civil penalty of at least one hundred thousand

dollars ($100,000) but not more than two hundred thousand dollars ($200,000).

(b) In determining the amount of a civil penalty under this section, the commissioner shall consider whether the health maintenance organization's failure to achieve the standards established by this chapter is due to circumstances beyond the health maintenance organization's control.

(c) A health maintenance organization may contest a civil penalty imposed under this section by requesting an administrative hearing under IC 4-21.5 not more than thirty (30) days after the health maintenance organization receives notice of the assessment of the fine.

(d) If the commissioner imposes a civil penalty under this section, the commissioner may not impose a penalty against the health maintenance organization under IC 27-4-1 for the same activity.

(e) Civil penalties collected under this section shall be deposited in the state general fund.

SECTION 7. [EFFECTIVE JULY 1, 2001] **(a) IC 5-10-8.1, as added by this act, applies to a self-insurance program or contract with a prepaid health care delivery plan that is established, issued, entered into, or renewed after June 30, 2001.**

(b) IC 27-8-5.7, as added by this act, applies to an accident and sickness insurance policy (as defined in IC 27-8-5-1) that is issued, entered into, delivered, or renewed after June 30, 2001.

(c) IC 27-13-36.2, as added by this act, applies to a health maintenance organization contract issued, entered into, delivered, or renewed after June 30, 2001.

(d) This SECTION expires July 1, 2006.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Approved: _____

Governor of the State of Indiana